Washington State Department of Social & Health Services

DIVISION OF DEVELOPMENTAL DISABILITIES

PLAN OF CARE ADDITIONAL SECTION FIVE

NAME:	DDD NUMBER:

Needs Assessment Number ______________________________

What steps must be taken and/or what services/supports need to be in place to meet this need?	Provider/ Responsible person?	Check if Waiver Funded Service	Frequency? Daily/Wkly/Mthly Quantity: Hrs/Days/Mths	If new, what is the start date?	Prior approval received if needed

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